Enteritis in Inherited Syphilis.

This paper is based on observations made by MRACEK at the Pathological Institute of Prof. Kundrat in Vienna (*Viertelj. für Derm. und Syph.*, Heft 2, 1883). Syphilitic affections of both ends of the alimentary canal have long been recognized, but their occurrence in the small intestine has been doubted. In acquired syphilis in adults, such lesions are excessively rare. In children with the inherited form of disease they are more common, but not so frequent as Birch-Hirschfeld's observations (five cases of intestinal lesion in forty of syphilis) would seem to show. In a series of about two hundred examinations, made up of children who themselves bore marks of syphilis, and of still-born children of syphilitic mothers, Mracek found ten cases of syphilitic disease of the intestines. In the present paper six of these cases are related in detail, and some others of a similar nature are referred to. From these cases it appears that syphilitic disease of the intestine occurs in two forms: (1) as a diffused inflammatory process extending over the whole or large areas of the gut, or (2) as circumscribed nodules limited to certain portions of the intestine In the first form, the infiltrated patches, in the earliest stage, are only distinguished from the normal tissue by their rigidity and pale yellow colour. In a more advanced stage, the infiltrations which occupy Peyer's patches have a pitted or dimpled appearance, and stand out clearly from the surrounding parts. The circumscribed nodules are almost always limited to the small intestine. Rarely is the stomach or large intestine affected. They are most frequently found in the upper part of the jejunum; not in the lower part of the ileum, which is often the seat of other morbid changes. The nodules are scattered irregularly over the gut, and vary from the size of a millet-seed to that of a lentil. They are situated chiefly in the deeper part of the submucous tissue, or between the muscular layers, or in the circular fibres. From the outside they appear as yellowish spots; from within they are distinguished by the reddened mucous membrane which covers them. Over the largest nodules the mucous membrane is mostly rigid and smooth, but never dimpled or pitted as in the infiltrated form of growth. The nodules grow towards the serous surfaces, which in the end become congested and thickened. Sometimes also the intestines become adherent to each other or to the abdominal walls. The nodules also tend to degenerate and break down. Both forms consist essentially of a small-celled growth of the intestine wall, but the infiltrated variety attacks especially the gland structures, particularly Peyer's patches. The nodules are scattered irregularly in roundish groups. The change begins as an infiltration of the adventitia of the smaller arteries; in the infiltrated form it originates in the vessels which surround the patch; in the nodular form it begins in the central vessels. The arteries become thickened, narrowed, and finally blocked, the result of which is degeneration of the new growth. The capillaries usually remain unaffected or are simply widened. At a later period the veins undergo a change similar to that of the arteries, but to a less degree. The lymphatics, especially those between the muscular layers and beneath the serous coat, also participate in the change to a slight extent. In two cases, both eight months' fœtuses, perforation of the gut had occurred, with consequent purulent peritonitis. These cases show that the change may occur rapidly *in utero*. Intestinal lesions have not yet been found before the seventh month of intra-uterine life. Besides the changes in the intestine, the meconium was also found to be thick and tenacious in several cases. In one case, no meconium was discharged for over fifteen hours. The syphilitic growth may also lead to irregular narrowing of the lumen of the intestine by the inward projection of the nodules; but the author has never seen the ring-like strictures

described by Oser. The mesenteric glands were always enlarged and infiltrated. In no case was the intestine alone affected by syphilis. There were constantly disease of the liver and spleen, and osteochondritis. Often also, in the most severe instances, there were changes in other organs —*e.g.* the lungs, brain, or kidneys, as well as different kinds of disease of the bones. To the paper is appended a series of drawings showing the most marked histological changes found in the cases which were examined by the author, and also a list of authors who have written on the subject of syphilis of the intestines.—*London Med. Record*, Feb. 1884.

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Gangrene of one Lung, and Lung Cavities treated by Drainage.

At a late meeting of the Royal Medical and Chirurgical Society two very important papers were read, in which the operative treatment of pulmonary disease was considered.

Dr. CAYLEY read a paper in conjunction with Mr. Pearce Gould on Gangrene of the Lung treated by Drainage, with Recovery. The patient was a girl aged twelve, who was admitted into the Middlesex Hospital on Jan. 18th. Four years ago she had had scarlet fever, which was followed by otorrhœa. On admission there was an acute abscess over the mastoid process on the left side, and extensive denudation of the bone about the external auditory meatus. The abscess was opened, and Mr. Gould, after trephining the mastoid process, gouged away some soft necrosed bone from the interior of the temporal bone. The patient progressed favourably till Jan. 28th, when symptoms of pyæmia developed. She had repeated rigors, with high fever of a strongly remittent type. On Feb. 2d signs of pleurisy with consolidation at the base of the right lung appeared. On the 7th her breath became offensive, and she began to spit up small quantities of stinking pus. On the 16th, these symptoms having continued, and the child having become extremely emaciated and prostrate, it was decided to drain the gangrenous cavity. There was now dulness over the right base as high as the angle of the scapula, and at one point some bubbling crepitation. Mr. Gould accordingly punctured the lung with a large-sized trocar and canula, and introduced through the latter a drainage-tube. Stinking pus and a sequestrum of gangrenous lung were discharged through the tube. The child rapidly improved, and was discharged on March 27th.

Dr. CECIL Y. BISS read a paper on the Treatment of Pus-secreting Basic Cavities of the Lung by the Method of Paracentesis and Free Drainage. The author groups pus-secreting basic lung cavities under three heads: (1) Those in which paracentesis is imperatively called for; (2) those in which it is unjustifiable; and (3) those in which it is a question of special difficulty whether it should be performed or not. A case was then related illustrative of the last group. A man aged thirty-two, with a satisfactory family history, and who had not suffered from any previous pulmonary disease, had been affected with cough and profuse expectoration for six months. On admission to hospital he presented at the right posterior base dulness, reaching as far as the spine of the scapula, with absence of breath-sounds and vocal fremitus. The heart's apex beat was half an inch outside the nipple-line. The case was regarded as one of abscess at the base of the lung, with slight effusion into the adjacent pleura. An exploratory puncture failed, however, to detect any fluid. Soon afterwards obscure friction sounds developed over the dull area, and then loud cavernous respiration with intensified voice sounds, the pyrexia and hectic symptoms becoming more marked. About a fortnight later—medicinal means having failed to give relief—a second exploratory puncture was made with negative results, except that the lung was